



ARTVENTURE AMBASSADOR MEDICAL STATUS FORM

Name of Ambassador: _____

Date of Birth: _____ Age _____

Name of Parent/Guardian _____

Home Address _____

Parent Telephone: (c) _____ (w) _____ (h) _____

Emergency Contact Name _____
(if parent cannot be reached)

Emergency Contact Phone: _____

Please list any allergies applicant has:

Is the applicant taking any medications that we should know about? If so, please list below.

Please Note: VisArts Staff will not administer, dispense, or store any medications, with the exception of emergency medications such as Epi Pen.

Please list any special needs the ambassador volunteer may have that we should know about:

I verify that _____ is in reasonably good health and to the best of my knowledge is free from any communicable diseases. I further verify that

_____ has received the standard immunizations required by the state of Virginia.

Signature of Parent /Guardian

Date

Printed Name